(c) Determination Appeal

(1) Any hospital may submit a written request to the Department for reconsideration of the determinations made under Sections 102D(b) and 102D(c) of this manual within twenty (20) days of notice of the determinations. The request shall be accompanied by written materials setting forth the basis for the reconsideration. If one (1) or more hospitals submit a request, the Department shall hold a public meeting within twenty (20) days from the last date on which reconsideration requests may be received. The Department shall mail written notice of the date, time and location of the hearing to every hospital at least ten (10) days before the date of the hearing. On the basis of the evidence submitted to the Department or presented at the hearing, the Department shall reconsider and may adjust the determinations.

(2) Within twenty (20) days of the public hearing, the Department shall provide notice in writing to each hospital of the final determination of the amount it is required to pay and is eligible to

receive. Any hospital may appeal the decision of the Department as to the amount it is required to pay or is eligible to receive to Franklin Circuit Court.

(d) Audit Function

(1) The Department shall conduct annual audits of the Hospital Indigent Care Assurance Program to determine that amounts received from, or paid to, hospitals were correct.

(2) If an audit conducted by the Department under this Section identified amounts that, due to errors by the Department, a hospital should have, or should not have received, the Department shall effect the appropriate correction by:

-adjusting the benefit amount calculated under Section 102D(b) of this manual; or by
-other means as deemed necessary by the Commissioner of Medicaid Services.

103. INFLATION FACTOR:

The inflation factor index to be used in the determination of the prospective rate will be established by the Program. The index will be based on Data Resources Inc., forecasting in conjunction with relative weights developed by the Health Care Financing Administration. The forecasted index represents the average inflation rate for the year and will have general applicability to all participating hospitals. The forecasted index utilized by the program will remain in effect for the prospective rate year.

For universal rate years beginning prior to January 1, 1985, an adjustment to the prospective rate will be made to the extent that actual inflation differs from the projected inflation index as measured by that index. For universal rate years beginning on or after January 1, 1985, no adjustment will be made to the prospective rate if actual inflation differs from the projected inflation index.

104. NEW PROVIDERS:

(a) CHANGE OF OWNERSHIP. When a hospital undergoes a change of ownership, the new owner will continue to be reimbursed at the prospective rate in effect. The new owner may appeal its rate subject to the provisions of Section 111. If at the time of the next prospective rate setting, the hospital does not have twelve (12) full months of actual costs in the fiscal year for which the cost report is submitted, the Department will use a partial fiscal year cost report to arrive at a prospective rate. This cost will be annualized and indexed appropriately.

(b) NEWLY CONSTRUCTED OR NEWLY PARTICIPATING HOSPITALS. Until a fiscal year end cost report is available, newly constructed or newly participating hospitals must submit an operating budget and projected number of patient days within 30 days of receiving Medicaid certification. A prospective rate will be set based on this data, not to exceed the upper limit for the class. This prospective rate will be tentative and will be subject to settlement at the time the first audited fiscal year end report is received from the Medicare intermediary. During the projected rate year, the budget can be adjusted if indicated, and justified by the submittal of additional information.

105. OCCUPANCY FACTOR:

To assure that only Program costs are compensated under this payment system and to encourage maximum occupancy, a minimum occupancy level will be imposed relative to Medicaid inpatient capital costs based on certified beds available during the prior year.

Facilities with 0-100 certified beds will have a minimum occupancy factor of 60% applied. Those facilities with 101 or more certified beds will have an occupancy factor of 75% applied.

Newly constructed hospitals opening on or after January 1, 1982, and beginning participation in the KMAP program on or after January 1, 1982, will be allowed one full rate year before the minimum occupancy factor is applied.

106. UNALLOWABLE COSTS:

The following costs will not be considered allowable costs for Medicaid reimbursement:

a) Costs associated with political contributions.

b) The costs associated with legal fees for unsuccessful lawsuits against the Cabinet. Legal fees relating to lawsuits against the Cabinet will only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or when otherwise agreed to by the parties involved or ordered by the court.

c) The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities. However, costs (excluding transportation costs) for training or educational purposes outside the Commonwealth of Kentucky are allowable costs. Even though such meetings per se are not educational, costs (excluding transportation) are allowable if educational or training components are included.

d) Amounts paid to the Commonwealth of Kentucky as tax assessments or penalties under the Hospital Indigent Care Assurance Program.

As the above referenced costs are currently not identified by the Medicare/Medicaid cost report, hospitals, beginning with fiscal years starting March 1, 1982 or later, shall identify these costs on annual cost reports submitted thereafter. An additional schedule, Supplemental Medicaid Schedule KMAP-1, shall be completed and submitted with the annual cost report. The purpose of the Supplemental Medicaid Schedule KMAP-1 is to identify these unallowable costs for exclusion from the prospective rate computation.

Due to the fact that the Kentucky Medical Assistance Program reimburses hospitals for transplants at the lower of a percent of charges or a flat fee amount, the costs associated with transplants shall not be included in allowable Medicaid costs. The charges and costs shall be reported in total hospital charges and total hospital costs but shall not be included in Title XIX charges or payments.

107. RETROACTIVE SETTLEMENTS:

Revision of the prospective payment rate will be made under the following circumstances:

(a) If incorrect payments have been made due to computational errors, i.e., mathematical errors, discovered in the cost basis or establishment of the prospective rate. Omission of cost data does not constitute a computational error.

(b) If a determination is made by the Program of misrepresentation on the part of a facility.

(c) For universal rate years beginning prior to January 1, 1985, if the actual inflation for the period differs from the projected index utilized, a settlement will be made to the extent of the difference. For universal years beginning on or after January 1, 1985, there will be no settlement made if the actual inflation factor differs from the projected index.

(d) For universal rate years beginning prior to January 1, 1985, if an audited cost report(s) alters the cost basis for the prospective rate, a settlement will be made. For universal rate years beginning on or after January 1, 1985, if unaudited data is utilized to establish the universal rate, the rate will be revised when the audited cost report is received from the fiscal intermediary.

In the event that circumstances (a) or (b) occur, a settlement

or revision will be made only after the audited cost report is received from the fisal intermediary. Factors which may affect the cost basis are 1) costs utilized in determining Medicaid capital costs, i.e., total inpatient cost and total capital cost, 2) Medicaid return on equity, and 3) Medicaid allowable costs.

In accordance with Title XIX (Medicaid) regulations at 42 CFR 447.271, Medicaid payments for inpatient hospital services will be adjusted for the lesser of total prospective payments or customary charges at the end of the prospective rate year. There will be no allowance made under the prospective system for the carry forward provision utilized by Medicare (Title XVIII) in regard to the lesser of prospective payments or customary charges for inpatient services.

108. COST REPORTING REQUIREMENTS:

Each hospital participating in the Kentucky Medical Assistance Program shall submit an annual cost report, (HCFA 2552) including the Supplemental Medicaid Schedule KMAP-1, in the manner prescribed by the Medicaid Program. The cost report shall be submitted within ninety (90) days after the close of the fiscal year. Facilities may write and request a thirty (30) day extension, explaining why the extension is necessary. The Program may grant the extension of thirty days. When the extension period has lapsed, the Program will then suspend all payments to the facility until an acceptable cost report is received. The reports must be filed for the fiscal year used by the facility unless otherwise approved by the Program.

ACCESS TO SUBCONTRACTOR'S RECORDS. When the facility has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for services costing or valued at $10,000 or more over a 12-month period, the contract must contain a clause giving the Department access to the subcontractor's books. Access must also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor. The contract shall contain a provision allowing access until four years have expired after the services have been furnished.